Medical Assistance Provider Bulletin

Attention: All Physicians, Physician Clinics, Independent and Clinic Laboratories, Portable X-ray Providers

Subject: Reimbursement and Policy Update

Date: January 1, 1985

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This Bulletin contains important information concerning the following subjects:

I. CALENDAR YEAR 1985 FEE UPDATES

II. CHANGES RESULTING FROM THE DEFICIT REDUCTION ACT OF 1984

III. NON-COVERAGE OF PROPOXYPHENE NAPSYLATE PRODUCTS

IV. ADDITION OF LESS-THAN-EFFECTIVE DRUG

V. SECOND SURGICAL OPINION PROGRAM CHANGES AND CLARIFICATIONS

I. Calendar Year 1985 Fee Updates

Effective for dates of service on and after January 1, 1985, maximum allowable fees for physician services will be updated to reflect an overall 3% increase as allowed by the Wisconsin State Legislature. For each covered service billed to the Wisconsin Medical Assistance Program (WMAP), a provider will be reimbursed at the lesser of the provider's usual and customary charge or the updated maximum allowable fee for the service. As explained below (Item II), the maximum allowable fees for clinical diagnostic laboratory services will be adjusted to reflect limits on the availability of federal funding specified in federal law.

After January 15, 1985, the WMAP will make available copies of the updated maximum allowable fee schedule. Providers may request the schedule by writing to:

Records Custodian
Bureau of Health Care Financing
Wisconsin Division of Health
P.O. Box 309
Madison, WI 53701

The written request must specify what fee schedule is requested (e.g., "Physician Fees 1/1/84" or "Physician Fees 1/1/85"), and whether the schedule is requested on computer printout ($25.03) or microfiche ($.49). The State requires prepayment before delivery of any public documents. Checks should be made out to the Department of Health and Social Services.

II. Changes Resulting from the Deficit Reduction Act of 1984

Reimbursement for Outpatient Clinical Diagnostic Laboratory Tests: Section 2303 of the federal Deficit Reduction Act of 1984 (P.L. 98-369) provides that for outpatient clinical diagnostic laboratory tests performed by a physician or laboratory, federal funding will not be available on amounts paid by Medical Assistance in excess of the amounts that Medicare recognizes for such tests. In accordance with this provision, effective for dates of service on and after January 1, 1985, the maximum allowable fee for each affected laboratory service will be set at no more than the amount allowed by Medicare.

This limitation on reimbursement applies to all independent and clinic laboratories for clinical diagnostic laboratory tests listed in codes 80002 - 89399 of the Current Procedural Terminology Fourth Edition (CPT 4-1984) and any subsequent additions, with the following Medicaid exceptions:

85095 - 85109	Codes dealing with bone marrow smears and biopsies
85120	Bone marrow transplant
88104 - 88130	Certain cytopathology services
88160 - 88199	Certain cytopathology services
88260 - 88299	Cytogenetic studies
88300 - 88399	Surgical pathology services.

Physician Billing for Laboratory Services: The Deficit Reduction Act of 1984 eliminated the WMAP's authority to allow billing by a physician for clinical diagnostic laboratory tests that are not personally performed or supervised by the physician. Accordingly, effective for dates of service on and after March 1, 1985, a physician may no longer bill and be reimbursed for clinical diagnostic laboratory tests that are not personally performed or supervised by the physician. Reimbursement for clinical diagnostic laboratory tests will be allowed only to the provider performing the tests. Physicians may continue to bill and be reimbursed for procedure 99000, "preparation and/or handling fee," which includes collection, preparation and/or handling charges for forwarding a specimen to an outside laboratory. Physicians are advised to contact the outside laboratory (independent lab or hospital-based lab) with which they work to make arrangements consistent with this policy.

In accordance with this policy, physicians may not, after March 1, 1985, exercise billing option number 2 for laboratory services explained on page K6-007 of the WMAP Physicians Handbook.

Providers should note that this policy is consistent with a policy implemented by Medicare in September of 1984.

III. Non-Coverage of Propoxyphene Napsylate Products

Effective for dates of service on and after February 1, 1985, propoxyphene napsylate products (e.g., Darvocet-N) will no longer be covered by the WMAP.

The Medicaid Medical Audit Committee of the State Medical Society recommended that physicians be informed that physicians wishing to obtain the analgesic properties of these products may substitute propoxyphene hydrochloride compounds of propoxyphene, which are covered by the WMAP and have comparable clinical value at a much lower cost.

IV. Addition of Less-Than-Effective Drug

The following drug and dosage type is to be included in the "Less-Than-Effective" drugs list, and will no longer be reimbursable effective February 1, 1985:

Tuss-Ornade (Caramiphen Edisylate, Chlorpheniramine Maleate, Isopropamide Iodide, Phenylpropanolamine HCl) Liq/Oral.

V. Second Surgical Opinion Program Changes and Clarifications

New Second Surgical Opinion Program address: The new mailing address for the Second Surgical Opinion Program (SSOP) is:

Second Surgical Opinion Program
Center for Health Systems Research & Analysis
1225 Observatory Drive
Madison WI 53706

New Request Forms: Effective immediately, providers wishing to submit a "Request for Approval of Elective Surgery" to the Second Opinion Program should do so on the revised form (see sample copy enclosed with this bulletin). The new form is designed to allow faster processing of SSOP cases. (Note: Old forms may be used until new forms are obtained, but providers are urged to write for new forms as soon as possible to avoid delays.) Additional copies of the new SSOP request form may be obtained by writing to the State's fiscal agent:

EDS Federal Corporation
Attn: Claim Recorder Dept.
6406 Bridge Road
Madison WI 53784

Once a supply of the new forms has been obtained, the old SSOP forms should be discarded.

The Basic Second Opinion Process Remains the Same: For a listing of the surgical procedures requiring second opinions and a complete discussion of the program, please refer to the WMAP Physician's Provider Handbook, section K3-001 and K7-027. None of these procedures when performed under urgent or emergent circumstances requires a second opinion. Billing instructions for procedures performed under urgent or emergent circumstances are described in Section K3-002 of the Handbook.

Physicians Providing Second Opinions: As of February 1, 1985, appointments for second opinion examinations must be made only with physicians currently registered with the SSOP as willing to provide second opinions. Any physician wishing to add his or her name to SSOP files of participating physicians should return the enclosed postcard or telephone the SSOP office.

Special Circumstances: Spanish-Speaking Patients, Patients Requiring Wheelchair Access: The Second Surgical Opinion Program would like to facilitate access to physician services required under this program. Accordingly, we would like to know about any physician's office that employs a Spanish-speaking staff person able to assist with patients who speak only Spanish, or whose primary language is Spanish. Similarly, we would like to know which offices are accessible to patients in wheelchairs. If your office can help in either of these special circumstances, please complete and return the postpaid postcard enclosed with this bulletin or call the SSOP staff.

Clarification of D & C's:

Only those D&C's properly coded 58120, "Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)", when done on an elective basis, are included in the second opinion requirement.

Second opinions are not required when performed in response to postpartum hemorrhage (59160); when performed in conjunction with a conization or biopsy of the cervix (57520); or when performed to rule out endometrial carcinoma in cases of postmenopausal bleeding (code 58120, billed as "urgent" with explanatory documentation).

Clarification: Secondary Tonsillectomy and/or Adenoidectomy: Tonsillectomy or adenoidectomy, when performed secondary to the necessary insertion of ventilation tubes in the ears, does not require a second opinion. If tube placement is the primary procedure, and tonsillectomy/adenoidectomy is deemed advisable at the time of surgery, explanatory documentation (history, physician and operative note) should be attached to the claim when billing for the procedures, as in billing for urgent surgery.

Toll-Free Telephone Numbers: The WMAP Second Surgical Opinion Program may be telephoned toll-free by recipients and providers with questions about the program. In Wisconsin, dial 1-800-362-3020 and ask the operator for the "Second Opinion Program." Outside Wisconsin, dial 1-800-262-6243 and ask the operator for the "Second Opinion Program."